Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MH SURGERY CENTER W HOUSTON
970 CAMPBELL ROAD
HOUSTON TX 77024

Respondent Name
INDEMNITY INSURANCE CO OF NORTH AMERICA

Carrier's Austin Representative Box
Box Number 15

MFDR Date Received
JANUARY 17, 2012

MFDR Tracking Number
M4-12-1651-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Not following ASC medical fee guideline."

Amount in Dispute: $1,395.35

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 11, 2011	ASC Services for CPT Code 29881-LT-SG	$1,395.35	$1,395.35

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - Z710-The charge for this procedure exceeds the fee schedule allowance.
   - Z951-We are unable to recommend an additional allowance since this claim was paid in accordance with the state's fee schedule guidelines, First Health Bill Review's usual and customary policies, and/or was reviewed in accordance with the provider's contract with First Health.
   - W1-Workers Compensation State Fee Schedule Adjustment.

Issues

1. Does a contractual agreement issue exist in this dispute?
2. Is the requestor entitled to additional reimbursement for CPT code 29881?

Findings

1. According to the explanation of benefits, the carrier paid the services in dispute in accordance with the state's fee schedule guidelines or with a contract with First Health.. The "NTWRK RDCTNS" amount on the submitted explanation of benefits denotes a "0.00" discount. The Division finds that documentation does not support that the services were discounted due to a contract; therefore, reimbursement for the services will be reviewed in accordance with applicable division rules and guidelines.
2. 28 Texas Administrative Code §134.402(d) states " For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section."

   28 Texas Administrative Code §134.402(f)(1)(A) states "The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the *Federal Register*. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the *Federal Register*, or its successor. The following minimal modifications apply: (1) Reimbursement for non-device intensive procedures shall be: (A) The Medicare ASC facility reimbursement amount multiplied by 235 percent."

   CPT code 29881 is defined as "Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed."

   According to Addendum AA, CPT code 29881 is a non-device intensive procedure.

   The City Wage Index for Houston, Texas is 0.9824.

   The Medicare fully implemented ASC reimbursement for code 29881 CY 2011 is $1,161.03

   To determine the geographically adjusted Medicare ASC reimbursement for code 29881:

   The Medicare fully implemented ASC reimbursement rate of $1,161.03 is divided by 2 = $580.51

   This number multiplied by the City Wage Index is $580.51 X 0.9824 = $570.29.

   Add these two together $580.51 + $570.29 = $1,150.80.

   To determine the MAR multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235%

   $1,150.80 X 235% = $2,704.38. The respondent paid $ 1306.40. The difference between the MAR and amount paid is $1,397.98. The requestor is seeking dispute resolution for a lesser amount of $1,395.35. As a result, this amount is recommended for additional reimbursement.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports additional reimbursement sought by the requestor. The Division concludes that the requestor supported its position that additional reimbursement is due. As a result, the amount ordered is $1,395.35.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,395.35 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	05/30/2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.